

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 002408	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/09/2015
NAME OF PROVIDER OR SUPPLIER DUPONT HOSPITAL LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2520 E DUPONT RD FORT WAYNE, IN 46825		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for investigation of one State hospital complaint.</p> <p>Facility Number: 002408</p> <p>Date: 2/9/15</p> <p>Complaint Number: IN00162424</p> <p>Substantiated; no deficiencies cited related to the allegations.</p> <p>Surveyor: Linda Plummer, R.N., Public Health Nurse Surveyor</p> <p>Dupont Hospital LLC is in compliance with 410 IAC 15-1.5-5, Medical Staff, and 410 IAC 15-1.5-6, Nursing Services, Indiana Hospital Licensure Rules.</p> <p>QA: cloughlin 03/10/15</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE